Office of the Defender General
State of Vermont
Certification of Health Care Provider - Family Member
(Family and Medical Leave Act of 1993)
(Vermont Parental and Family Leave)

This form is to be completed when the employee needs family leave to care for a FAMILY MEMBER with a "serious illness."

Employee's Name: _____ Department: _____

Name of Family Member:_____ Relationship: _____

Release of Medical Information: I authorize the release of any medical information necessary to provide the information requested on this form.

Patient's OR Patient Guardian's Signature:_____Date:_____

SERIOUS HEALTH CONDITION:

1. The Family and Medical Leave Act Information Sheet describes what is meant by a **"serious health condition"**[1] under the State and Federal Family and Medical Leave Acts. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

_____(1) Hospital Care
_____(2) Absence Plus Treatment
_____(3) Pregnancy
_____(4) Chronic Conditions Requiring Treatments
_____(5) Permanent/Long-Term Conditions Requiring Supervision
_____(6) Multiple Treatments (Non-Chronic Conditions)
_____(7) None of the above: Please specify why leave is required

Date Condition Began: _____
Date Condition Expected to End: _____

2. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one or more of these categories:

TREATMENTS:

3. Will the patient be absent from work or other daily activities on an **intermittent** or **reduced schedule** basis because of **treatment**?

_____Yes
_____No
If Yes: Number of treatments: _____
Interval between treatments:_____
Dates of treatments:_____
Period of recovery:_____

[1] Here and elsewhere on this form the information sought relates only to the patient's condition for which the employee is taking FMLA

4. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

5. If a **regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

INCAPACITY:

6. Is the patient **presently incapacitated[2]?**
   _____Yes
   _____No
   If yes, give the probable duration:_____

7. If the condition is a **chronic condition** or **pregnancy**, are **episodes of incapacity likely**?
   _____Yes
   _____No
   If yes, give the probable duration of episodes:_____
   If yes, give the probable frequency of episodes:_____

CARE PROVIDER:

8. **Does the patient require assistance** for basic medical or personal needs or safety, or for transportation?
   _____Yes
   _____No
   If yes, give the probable duration:_____

9. Would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?
   _____Yes
   _____No
   If yes, give the probable duration:_____

Signature of Physician or Health Care Provider: _____ Date: _____

_____
(Address) (Telephone Number)

Type of Practice or Specialization: _____
_____

To be completed by the EMPLOYEE needing family leave to care for a family member:

State the care to be provided by the employee and an estimate of the time period necessary to provide this care. If an intermittent or reduced leave schedule is required, please include the schedule:

_____
(Employee Signature) (Date)

[2] Incapacity, for purposes of FMLA, is defined to mean the inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.